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April 4, 2008

DECISION AND ORDER
OFFICE OF HEARINGS AND APPEALS

Hearing Officer's Decision

Case Name: Personnel Security Hearing

Date of Filing: November 13, 2007

Case Number: TSO-0565

This Decision concerns the eligibility of XXXX XXX XXXXXXX (hereinafter referred to as "the individual") to hold an access authorization under the regulations set forth at 10 C.F.R. Part 710, entitled "Criteria and Procedures for Determining Eligibility for Access to Classified Matter or Special Nuclear Material."[1/] A Department of Energy (DOE) Operations Office suspended the individual's access authorization under the provisions of Part 710. This Decision considers whether, on the basis of the evidence and testimony presented in this proceeding, the individual's access authorization should be restored. As set forth in this Decision, I have determined that the individual's security clearance should be restored.

I. Background

The provisions of 10 C.F.R. Part 710 govern the eligibility of individuals who are employed by or are applicants for employment with DOE, contractors, agents, DOE access permittees, and other persons designated by the Secretary of Energy for access to classified matter or special nuclear material. Part 710 generally provides that "[t]he decision as to access authorization is a comprehensive, common-sense judgment, made after consideration of all relevant information, favorable and unfavorable, as to whether the granting or continuation of access authorization will not endanger the common defense and security and is clearly consistent with the national interest." 10 C.F.R. § 710.7(a).

1/ An access authorization is an administrative determination that an individual is eligible for access to classified matter or special nuclear material. 10 C.F.R. § 710.5. Such authorization will be referred to variously in this Decision as an access authorization or security clearance.

The individual was granted a DOE security clearance after gaining employment with DOE. However, a DOE security office (DOE Security) initiated administrative review proceedings by informing the individual that her access authorization was being suspended pending the resolution of certain derogatory information that created substantial doubt regarding her eligibility. This derogatory information is described in a Notification Letter issued to the individual on October 15, 2007, and falls within the purview of potentially disqualifying criteria set forth in the security regulations at 10 C.F.R. § 710.8, subsections h and l. More specifically, the Notification Letter alleges that the individual has: (1) "has an illness or mental condition which in the opinion of a psychiatrist causes, or may cause, a significant defect in [the individual's] judgment and reliability," and (2) "engaged in unusual conduct or is subject to circumstances which tend to show that [she] is not honest, reliable, or trustworthy; or which furnishes reason to believe that [she] may be subject to pressure, coercion, exploitation, or duress which may cause [her] to act contrary to the best interests of national security." 10 C.F.R. §§ 710.8(h) and (l) (Criterion H and Criterion L, respectively). The bases for these concerns are described below.

In reference to Criterion H, the Notification Letter states that during Personnel Security Interviews (PSI's) conducted on April 25, 2005, on March 12, 2007, and March 19, 2007, the individual described her medical history which revealed that, since 1994, the individual had been under psychiatric care and prescribed a number of medications for chronic pain, depression and anxiety. The Notification Letter further indicates that, in January 2007, the individual apparently attempted to commit suicide. In May 2007, the individual was evaluated by a DOE consultant-psychiatrist (DOE Psychiatrist) who diagnosed the individual with Major Depressive Disorder, a condition which causes or may cause a significant defect in her judgment and reliability. With regard to Criterion L, the Notification Letter states that the individual had demonstrated a pattern of discontinuing medications without the prior approval of her treating physicians and not complying with their treatment recommendations.

In a letter received by the DOE Office of Hearings and Appeals on November 13, 2007, the individual exercised her right under Part 710 to request a hearing in this matter. 10 C.F.R. § 710.21(b). On November 14, 2007, I was appointed as Hearing Officer. I set a hearing date after conferring with the individual and the appointed DOE Counsel, 10 C.F.R. § 710.24. At the hearing, the DOE Counsel called the DOE Psychiatrist as DOE Security's sole witness. Apart from testifying on her own behalf, the individual called as witnesses her ex-husband, a close friend and former co-worker, her father, and her psychologist. The transcript taken at the hearing will be hereinafter cited as "Tr.". The DOE Counsel submitted seventeen enumerated exhibits in support of the Notification Letter, cited below as "DOE Exh.". The individual tendered two exhibits, cited as "Ind. Exh.".

Summary of Findings

The findings set forth below are essentially uncontroverted. However, I will indicate instances in which the parties have taken contrary positions regarding the information presented in the record.

The individual was hired by DOE in December 2004, and was granted a security clearance in October 2005. *See* DOE Exh.'s 2, 15. However, the individual's continued eligibility to hold a security clearance came into question in January 2007, when DOE Security received information that the individual had apparently attempted to commit suicide in her home by taking an overdose of prescription drugs (the January 2007 incident). DOE Exh. 12. This information prompted DOE Security to conduct two PSI's with the individual, on March 12, 2007, and on March 19, 2007. *See* DOE Exh.'s 16, 17. The individual was then referred to the DOE Psychiatrist who conducted a psychiatric evaluation on May 29, 2007, and issued a report of her findings and opinion on June 12, 2007. *See* DOE Exh. 8 (Report). Below is a summary of the facts and circumstances which culminated in the January 2007 incident, based upon information received during the PSI's, psychiatric interview and at the hearing. The record indicates, and the psychiatric experts agree, that the January 2007 incident was not an intentional suicide attempt but the result of the individual unwittingly taking a dangerous combination of prescription medications.

The individual began taking prescription medication on a regular basis in 1995, when she was prescribed Percocet (a combination of oxycodone with acetaminophen) to relieve chronic pain caused by a bilateral knee injury.[1/] The individual also suffers periodically from chronic foot pain (plantar fasciitis) and joint pain. Tr. at 70, 204; Report at 9-10. From 1995 to early 2007, the individual would typically take one or two Percocet during the day and, as needed, also take a prescription medication (Ambien) to sleep. Tr. at 117-18. In 1996, following the death of her mother, the individual started having migraine headaches and she was prescribed Zoloft, an anti-depressant medication that is also used to treat migraines. Report at 11. In 2000, the individual also began taking Allegra and Singular, allergy medications, because her doctor believed that her periodic migraine headaches might be caused by an allergy. Tr. at 118, 138.

2/ There is a discrepancy in the record regarding when the individual began taking Percocet. The DOE Psychiatrist's report states that the individual began taking Percocet in 1984, while the Notification Letter specifies the date as 1994. *See* Report at 9; DOE Exh. 1. At the hearing, however, the individual clarified that she began taking Percocet in 1995 and the DOE Psychiatrist concurred with this correction. Tr. at 170, 213-14.

In 2001, the individual accepted a job offer in XXXXXXX, and moved there with her husband. Tr. at 15. Prior to moving to XXXXXXX, the individual seldom drank alcohol. While living in Europe, however, she acquired the habit of drinking a few glasses of wine with dinner nearly every evening, although she continued to take prescription medications. Tr. at 49-50; Report at 12. In 2003, the individual's husband began to experience serious health problems that required him to return to the United States for adequate health care coverage. Tr. at 19-20. Later during that same year, while the individual was living alone in XXXXXXX, her sister died suddenly and her favorite cat died shortly thereafter. Tr. at 15-16. As a result to this combination of events, the individual had a period of depression lasting a few months, with symptoms including crying spells, insomnia, fatigue and not wanting to go out. Tr. at 139; Report at 11. In July 2004, the individual consulted a doctor who decided to increase her dosage of Zoloft, with their mutual agreement that the individual could resume her normal dosage when she felt better. Tr. at 140-41. The individual resumed her normal dosage of Zoloft after about three weeks. Tr. at 141. The individual returned to the United States in late 2004, when she accepted a job with DOE.

In August 2006, the individual's husband informed her that he wanted a divorce, after 22 years of marriage. Tr. at 24. The individual was devastated by this sudden pronouncement and she began experiencing high levels of anxiety and panic attacks sometimes lasting up to two hours, during which she had difficulty breathing and felt like she was having a heart attack. Tr. at 56-57; Report at 11-12. The individual went to her Employee Assistance Program counselor on two or three occasions but did not continue these counseling sessions. Tr. at 144. Her physician (Treating Physician) prescribed Alprazolam, a generic form of Xanax, to treat her anxiety attacks. Report at 3; Tr. at 118. During this time, the individual continued to take her other prescription medications including Percocet, Zoloft, Allegra and Ambien, and to consume alcohol on a regular basis. In December 2006, the Treating Physician decided to take her off Zoloft and to place her on Lexapro, an alternative anti-depressant medication that he believed might better alleviate her anxiety attacks. Tr. at 119, 139.

In early January 2007, the individual had a falling accident and hurt her shoulder. To alleviate the severe pain from this injury, the individual's Treating Physician prescribed Fentanyl, a strong narcotic medication which is administered by wearing a three-day patch. Tr. at 119-20. The individual completed one three-day patch and had begun wearing a second patch when she began experiencing adverse side affects, including dementia and feeling as though she had to concentrate in order to breathe. Tr. at 121. During this time period, the individual's husband observed the individual behaving oddly on a couple of occasions, when she performed household chores late at

night while apparently walking in her sleep. Tr. at 27-28, 42-43, 57, 165.[1/] The individual also had an incident at work when she was informed by a co-worker that she was acting strangely. Tr. at 122. The individual therefore decided to remove the second Fentanyl patch before completing the full three-day cycle. *Id.* However, Fentanyl has a cumulative and lasting effect, and a substantial amount of the potent pain medication remained in her system. *Id.*

The individual has only a vague memory of the January 2007 incident. On the day of the incident, the individual's husband was out bowling with two female friends. Tr. at 23, 29. According to the individual, she had what she describes as "the anxiety attack from hell, the worst anxiety attack that I ever experienced." Tr. at 151. The individual stated that she took her normal dosage of two Xanax pills and waited an hour, but "I still felt like I was having a heart attack. It still felt like my chest was ripping open." Tr. at 151-52. The individual then decided to take two more Xanax pills with a vodka which, according to the individual, was the first time she ever took prescription medication with alcohol. Tr. at 151, 153.[1/] The next thing the individual remembers is the police standing over her, waking her and telling her that she had overdosed. Tr. at 123-24. According to the individual, she does not remember the police breaking into her home or her actions prior to their intervention. More specifically, the individual does not remember calling and talking to a co-worker, who later called the police out of concern, or calling and talking to her father. Tr. at 125. In addition, the individual does not remember writing a message, thought by the police to be a suicide note. The message is mostly illegible, but states in part: "I give up. Goodbye. The girls are more important than me . . . I don't think my suicide maybe really make . . . ." Ind. Exh. 2. The individual acknowledges that the note is her writing but she has consistently stated, during her PSI, psychiatric interview and at the hearing, that she did not attempt to commit suicide. *See* DOE Exh. 17 (March 12, 2007 PSI) at 27; Report at 7; Tr. at 148.

3/ Although the individual and her husband were in the process of getting a divorce, he continued to reside in their home until February 2007, sleeping downstairs on the couch at night. Tr. at 24.

4/ In describing the amount of vodka she drank during the January 2007 incident, the individual stated during her March 19, 2007, PSI that "it wasn't a whole bottle, but it was a sizeable amount." DOE Exh. 16 at 48. The individual testified she had never previously mixed alcohol with medication in this manner, clarifying that although she typically drank wine with dinner, she would take her medication earlier in the day or late in the evening, before bedtime. Tr. at 143.

The individual was remorseful, frightened and humiliated by the January 2007 incident, and she sought an explanation from her Treating Physician within a few days after being released from the hospital. Tr. at 126; *see* Tr. at 95-96, 194. The Treating Physician admitted that he should not have prescribed Fentanyl in combination with the other prescription medications she was taking. Tr. at 126. The individual realized that she had been too trusting of the Treating Physician. The individual decided to cease all consumption of alcohol, to reduce her medications and to seek a consultation from another physician (Evaluating Physician). Tr. 127, 154. The Evaluating Physician evaluated the individual on February 12, 2007, and concluded that the January 2007 incident was a "synergistic reaction" caused by the Fentanyl interacting with the Xanax and Ambien in the individual' s system. Ind. Exh 1 (Report of Evaluating Physician). He informed the individual that she is "lucky to be alive." The Evaluating Physician advised the individual to discontinue all medication except Lexapro and a non-narcotic sleep aid, and they discussed the possibililty of discontinuing Lexapro at a later date. *Id.* The individual stopped taking Lexapro in March 2007. Tr. at 154. As noted above, the individual was evaluated by the DOE Psychiatrist in May 2007. In July 2007, the individual began weekly counseling sessions with her psychologist (Psychologist).

II. Analysis

A DOE administrative review proceeding under 10 C.F.R. Part 710 is not a criminal matter, in which the burden is on the government to prove the defendant guilty beyond a reasonable doubt. *See Personnel Security Hearing,* Case No. VSO-0078, 25 DOE ¶ 82,802 (1996). In this type of case, we are dealing with a different standard designed to protect national security interests. A hearing is "for the purpose of affording the individual an opportunity of supporting his eligibility for access authorization." 10 C.F.R. § 710.21(b)(6). Once DOE Security has made a showing of derogatory information raising security concerns, the burden is on the individual to come forward at the hearing with evidence to convince the DOE that granting or restoring his access authorization "would not endanger the common defense and security and would be clearly consistent with the national interest." 10 C.F.R. § 710.27(d). This standard implies that there is a strong presumption against the granting or restoring of a security clearance. *See Department of Navy v. Egan,* 484 U.S. 518, 531 (1988) ("clearly consistent with the national interest" standard for the granting of security clearances indicates "that security determinations should err, if they must, on the side of denials"); *Dorfmont v. Brown,* 913 F.2d 1399, 1403 (9th Cir. 1990), *cert. denied,* 499 U.S. 905 (1991) (strong presumption against the issuance of a security clearance).

I have thoroughly considered the record of this proceeding, including the submissions of the parties, the evidence presented and the testimony of the witnesses at the hearing

convened in this matter. In resolving the question of the individual's eligibility for access authorization, I have been guided by the following applicable factors prescribed in 10 C.F.R. § 710.7(c)): the nature, extent, and seriousness of the conduct; the circumstances surrounding the conduct, to include knowledgeable participation; the frequency and recency of the conduct; the voluntariness of the participation; the absence or presence of rehabilitation or reformation and other pertinent behavioral changes; the motivation for the conduct; the potential for pressure, coercion, exploitation, or duress; the likelihood of continuance or recurrence; and other relevant and material factors. After due deliberation, it is my opinion that the individual's security clearance should be restored since I conclude that such restoration would not endanger the common defense and security and would be clearly consistent with the national interest. 10 C.F.R. § 710.27(d). The specific findings that I make in support of this determination are discussed below.

A. Criteria H; Mental Condition

(1) Derogatory Information

In her Report, the DOE Psychiatrist diagnosed the individual with Major Depressive Disorder, primarily based upon the period of depression the individual experienced in 2004 while living in XXXXXXX; the DOE Psychiatrist considers this to have been "a major depressive episode." Report at 19. The DOE Psychiatrist further opines in her report that, since 2004, the individual "has been in partial remission, but never in complete remission," as indicated by her continuing to take multiple prescription medications, her panic attacks starting in August 2006, and finally the January 2007 incident. *See id.* at 19-20. In addition, the DOE Psychiatrist expressed concern about the individual's use of alcohol in combination with her prescription medications and her continuing use of opiates to relieve her chronic pain. *Id.* at 20-21.

Based upon the diagnosis of the DOE Psychiatrist, I find that DOE Security properly invoked Criterion H in suspending the individual's security clearance. As observed by Hearing Officers in similar cases, a diagnosis of a mental condition raises serious security concerns. "Emotional, mental, and personality disorders can cause a significant defect in an individual's psychological, social and occupational functioning. These disorders are of a security concern because they may indicate a defect in judgment, reliability, or stability." *Personnel Security Hearing,* Case No. VSO-0224, 29 DOE ¶ 82,860 at 86,035 (2005); *see also Personnel Security Hearing,* Case No. VSO-0475, 28 DOE ¶ 82,832 (2001); *Personnel Security Hearing,* Case No. TSO-0014, 28 DOE ¶ 82,945 (2003). Accordingly, I will turn to the mitigating evidence presented by the individual to overcome these security concerns. On the basis of the testimony

and evidence described below, I have concluded that the security concerns under Criterion H have been resolved.

(2) Mitigating Evidence

At the hearing, the individual testified that she has made tremendous progress with respect to her mental condition and use of prescription medications since the January 2007 incident, and particularly since she started counseling sessions with the Psychologist in July 2007. The individual testified that she has remained abstinent from alcohol since the January 2007 incident, for a full year at the time of the hearing. Tr. at 154, 169.[1/] In addition, the only prescription medication that the individual now takes is Percocet, not on a daily basis but only as needed to alleviate her chronic pain. Tr. at 136, 169-70. The individual no longer takes any anti-depression, anti-anxiety or sleep aid medication. *Id.* The individual recognizes the great improvement she has made in handling stress since beginning counseling sessions with the Psychologist. The individual began by seeing the Psychologist every week, but now sees her every other two weeks. Tr. at 159, 179. The individual committed to continuing her sessions with Psychologist "as long as she wants me to go." Tr. at 159.

According to the individual, she feels "completely different" than she did during the months prior to the January 2007 incident. Tr. at 136. The individual realizes that she was too trusting in relying on her doctor and unwise in not questioning the medications he prescribed. Tr. at 129. She also acknowledged that she did not exercise good judgment in choosing to consume alcohol, even if only wine with dinner, while on anti-depressant and pain reducing medications. Tr. at 143. However, I found the individual forthright and convincing in stating her resolve that she will never make these mistakes again. Tr. at 130. The individual's ex-husband, close friend and father, confirmed the transformation the individual has undergone, stating that she now has a positive attitude about herself and that she is now well-equipped to handle stressful situations. Tr. at 31-32, 72, 99-100. Her close friend testified that there is a "night and day difference, 180 degrees" between the individual at the time of the hearing and one year previous. Tr. at 72.

The individual's Psychologist testified at length regarding the circumstances which precipitated the January 2007 incident and the progress the individual has made since then. The Psychologist initially stated that she did not agree with the DOE

5/ The individual's complete abstinence from alcohol since the January 2007 incident was corroborated by her ex-husband (who remains a close friend and sees her on nearly a daily basis), her father, and her Psychologist. Tr. at 35, 97, 192.

Psychiatrist's diagnosis of Major Depressive Disorder based upon the depression experienced by the individual in 2004,[1/] but conceded that the diagnosis was reasonable. Tr. at 180-81. The Psychologist more forcefully stated, however, that even assuming the DOE Psychiatrist's diagnosis was correct, the individual's depressive disorder must now be considered to be in full remission. Tr. at 181. The Psychologist explained that the January 2007 incident was not "a major depressive episode" but a "substance-induced mood disorder . . . the result of being on six central nervous system depressants, five of which were prescribed by the very same physician." Tr. at 181-82. She continued: "[W]hat the likely drug interactions were and what was likely to have occurred in terms of symptoms – paranoia, depression, confusion, and that's only Xanax. I mean if you add – let me see, Percocet, Fentanyl, which is supposed to be 50 to 100 times as strong as morphine, and you add alcohol, Ambien, which is notorious for problems with sleep-walking . . . [S]he was on a stew of medications that was very inappropriate, and she was trusting her physician to tell her what she could do." Tr. at 183.

The Psychologist testified that the individual has benefitted greatly from their sessions, which she characterized as "cognitive behavioral therapy," that equips the individual with "self-talk" and assertion skills to face stressors and manage anxiety. Tr. at 186-87, 191. The Psychologist pointed out that "cognitive behavioral therapy" has proven to be successful in nearly 60 percent of patients who formerly took anti-depressant medication to treat depression. Tr. at 188. The Psychologist corroborated the individual's testimony that Percocet now is the only prescription medication that she takes, on some days to relieve pain, and the Psychologist is working with the individual to minimize her use of Percocet by managing her chronic pain through alternative techniques such as exercise. Tr. at 192, 199-200. The Psychologist testified that the individual is currently having no problems with depression or anxiety, that the individual is "stable" and there is a "low" probability of a recurrence of the problems she has experienced in the past. Tr. at 191, 193, 201.

The DOE Psychiatrist testified last at the hearing. She first agreed with the Psychologist that the January 2007 incident was not a suicide attempt by the individual, but unconscious behavior "in a dissociative state" induced by the cocktail of prescription medications she was taking. Tr. at 218-19. "I agree most with what

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6/ The Psychologist explained during her testimony that, in her view, not all of the diagnostic criteria, as specified in the *Diagnostic and Statistical Manual of the American Psychiatric Association, IVth Edition TR*, were met to support a diagnosis of Major Depressive Disorder. Tr. at 180. Although, the Psychologist agreed that the individual had experienced depression in the past, but did not share the DOE Psychiatrist's opinion that the individual experienced a major depressive episode. Tr. at 194-94.

[the Psychologist] said was that this is really a case of mismanaged medications." Tr. at 220. The DOE Psychiatrist stood by her diagnosis of Major Depressive Disorder and explained her reasons for finding in her Report that the individual was only in "partial remission" in May 2007. Tr. at 226-28. On the basis of the evidence and testimony presented at the hearing, however, the DOE Psychiatrist concurred with the Psychologist that the individual is now "in full remission." Tr. at 232-33. The DOE Psychiatrist also agreed that cognitive behavioral therapy, such as that being received by the individual from the Psychologist, has proven to be an effective means of treating persons with chronic depression. Tr. at 233. Finally, the DOE Psychiatrist concurred with the Psychologist's opinion that the "risk is low" that there will be a recurrence of the individual's past depression to the extent that it causes a defect in the individual's judgment and reliability. Tr. at 234. In similar cases involving a diagnosis of a depressive disorder, Hearing Officers have held that the security concerns were resolved where there was agreement of the psychiatric experts that the depressive disorder was in remission and there was a low probability of a recurrence of the symptomatic behavior that raised the security concerns. *See, e.g, Personnel Security Hearing,* Case No. TSO-0072, 28 DOE ¶ 82,960 (2004); *Personnel Security Hearing,* Case No. TSO-0405, 29 DOE ¶ 82,976 (2006); *Personnel Security Hearing,* Case No. TSO-0349, 29 DOE ¶ 82,981 (2006).

B. Criterion L; Unusual Conduct

The security concerns stated in the Notification Letter under Criterion L are based upon statements made by the individual that, in the past, she took herself off prescribed medication without the prior approval of her doctor, and concerns expressed by the DOE Psychiatrist that the individual had not been totally forthcoming with her doctors. *See* DOE Exh. 1. The specific incidents cited in the Notification Letter are: (1) the individual's decision to stop taking a higher dosage of Zoloft prescribed for her in July 2004 for symptoms of depression, (2) her removal of the Fentanyl patch in January 2007, (3) her decision to discontinue Lexapro after the January 2007 incident without first consulting her Treating Physician, (4) her decision to stop taking Lexapro in March 2007, after she had resumed Lexapro on the advice of the Evaluating Physician, and (5) her failure not to report her concerns about her medication, or her use of alcohol, to her Treating Physician prior to the January 2007 incident. *Id.* I have determined that DOE Security has legitimately raised these Criterion L concerns but that they have been adequately mitigated based upon the record of this case.

First, regarding the individual's decision to discontinue the higher dosage of Zoloft in 2004, the individual explained that, during this time, she was working in XXXXXXX and the doctor she consulted was not her regular doctor. Tr. at 140-41. It was unclear whether there would be any opportunity for a follow-up visit with this doctor, and so

she and the doctor agreed that she could reduce her dosage of Zoloft to her normal level after she felt better. Tr. at 140. The individual resumed her normal dosage after about three weeks. *Id.* I found the individual candid in providing this explanation and I consider the matter resolved.

I am equally satisfied with the explanation provided by the individual regarding her decision to remove the Fentanyl patch (the second of two three-day patches) after she began to experience serious side affects. *See* Tr. at 121-22. I consider the individual's action in removing the patch to be reasonable under the circumstances. According to the individual, she sought to make an appointment with the Treating Physician to discuss the matter, but the January 2007 incident occurred before an appointment could be confirmed. Tr. at 123. I also find reasonable her decision to stop taking Lexapro until consulting with the Evaluating Physician. In wake of the January 2007 incident, the individual understandably had serious concerns with the medications that had been prescribed by the Treating Physician. The Evaluating Physician later advised the individual to continue taking Lexapro. Tr. at 154. However, the Evaluating Physician has corroborated the testimony of the individual that she had his approval to discontinue this medication. The Evalulating Physician's states in his report: "We discussed the possibility of discontinuing her Lexapro in the near future. . . . I advised her that Lexapro at 10mg dose she was on was a good starting and stopping point of treatment. There would be no concern of her stopping if she felt it was no longer needed." Ind. Exh. 1 at 1.

Finally, the individual has openly acknowledged that she was too trusting of her Treating Physician, and that she did not take proper time to ask questions about the medications he prescribed or to clarify whether the consumption of alcohol was allowed. Tr. at 129-30, 143. The individual was very convincing in vowing that this will never happen again, and that if she is prescribed medication: "I have a list, and that doctor is not leaving that room until I ask these questions, and at the very end saying, 'These are the prescriptions that I'm on, you know, is there any warnings I should know about?' . . . I'm going to make sure that I fully understand, I'm not going to rely on a pharmacy or a doctor." Tr. at 129-30. At the conclusion of the hearing, I asked the DOE Psychiatrist whether she had any lingering concerns about the individual's openness and honesty in dealing with her doctors. The DOE Psychiatrist responded that she now believes that the individual's judgment in the past was impaired by her medical conditions (chronic pain and depression) and medication, Tr. at 244-45, but "[a]t this time, I do not have that concern with her." Tr. at 249.

III. Conclusion

As explained in this Decision, I find that DOE Security properly invoked 10 C.F.R. §§ 710.8(h) and (l) in suspending the individual's access authorization. For the reasons described above, I find that the individual has sufficiently mitigated the associated security concerns. I therefore find that restoring the individual's access authorization would not endanger the common defense and security and would be consistent with the national interest. Accordingly, I find that the individual's security clearance should be restored. The Manager of the DOE Operations Office or the Office of Security may seek review of this Decision by an Appeal Panel under the regulations set forth at 10 C.F.R. § 710.28.

Fred L. Brown
Hearing Officer
Office of Hearings and Appeals

Date: April 4, 2008